PRINTED: 10/22/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185418	A. BUILDING _____ B. WING _____	C 09/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYD NURSING & REHABILITATION CENTER	1200 PRINCELAND DRIVE ASHLAND, KY 41102

RECEIVED
OCT 29 2010
BY:

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED A Recertification and an Abbreviated Survey, related to ARO #KY00015339, ARO #KY00015401 and ARO #KY00015404, was conducted on 09/21 -24/10. A Life Safety Code Survey was conducted on 09/22/10. Deficiencies were cited with the highest scope and severity of a "F". ARO #KY00015339 and ARO #KY00015404 were substantiated with no deficiencies cited. ARO #KY00015401 was substantiated with deficiencies cited.	F 000	To the best of my knowledge and belief, as an agent of Boyd Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	It is the policy of Boyd Nursing and Rehabilitation Center to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening condition or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as	10/16/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	10/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	185416	A. BUILDING _____ B. WING _____	C 09/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYD NURSING & REHABILITATION CENTER	12800 PRINCELAND DRIVE ASHLAND, KY 41102

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to inform Unsampled Resident #1's physician and family member of clinical complications related to elevated blood glucose levels. The findings include: Review of the facilities policy titled "Notification of Changes", dated 08/01/03, revealed the purpose of the policy was to ensure that a resident and their legal representative or family member are informed of changes in their medical condition and/or treatment. The policy statement included the resident, Resident's physician, and Resident's legal representative or family member will be notified when a life-threatening condition or clinical complications, or need to significantly alter treatment occurs. The policy indicated a licensed Nurse was to notify the Medical Doctor when a change in health status occurs, notify the resident's legal representative or family member unless the resident specifies they do not wish to notify. The licensed Nurse was to document the changes and who was notified which would be entered into the Nurses notes and revise the Care Plan as necessary.	F 157	specified in 483.12. The Physician visited Unsampled Resident #1 on 09/30/10 related to her blood glucose levels. New orders were received and implemented. The family designee was notified of the new orders on 09/30/10 by a licensed nurse. All resident records for the previous 30 days were reviewed by the Director of Nursing or designee by 10/11/10 to determine that physician and family notification had occurred as required. The physician was notified of any identified issues. Any new orders were received and notified. Director of Nursing and Administrator reviewed Notification of Change and Significant Change Policy on 09/30/10. No changes were made. All licensed nursing staff received additional education regarding the facilities Notification of Change and Significant Change policy. This education was completed by the Director of Nursing on 10/06/10. The Director of Nursing or designee will review ten charts each business day for four weeks (Monday-Friday) to ensure that appropriate notification has occurred. The results of these audits will be forwarded to the weekly Focus Committee (a sub-committee of the Continuous Quality Improvement Committee). Results will also be reviewed monthly by the Continuous Quality Improvement Committee (CQI) for	

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F 157	Continued From page 2 Review of Unsampled Resident #1 medical record revealed the resident was admitted with diagnoses which included Vascular Dementia and Uncontrolled Type II Diabetes Mellitus. Review of the Medication Administration Record (MAR) revealed instructions for sliding scale insulin dosage based on blood sugar levels. It was noted for blood glucose levels above four-hundred fifty (450) the Medical Doctor was to be notified.	F 157	further monitoring and continued compliance. The committee will determine, based on the results of audits received, how long monitoring should continue.	
	Review of Unsampled Resident #1's blood sugar levels for the month of August revealed six (6) instances of the resident's blood glucose levels being greater than four hundred fifty (450). The dates and the levels included 08/04/10 blood glucose level four-hundred ninety-six (496), 08/08/10 blood glucose level four-hundred sixty-nine (469), 08/10/10 blood glucose level four-hundred ninety-two (492), 08/18/10 blood glucose level five-hundred twenty-six (526), 08/23/10 blood glucose level four hundred eighty-nine (489) and 08/29/10 blood glucose four hundred eighty-two (482). Review of the Nurses' Notes for the month of August 2010 revealed no documented evidence the Medical Doctor was were notified of five (5) of the six (6) incidents of Unsampled Resident #1's elevated blood sugar levels. The Nurses' Notes indicated the Medical Doctor was notified of the occurrence on 08/18/10. However, the review revealed no documented evidence the family was notified of any of the resident's elevated blood sugar levels. Review of Unsampled Resident #1's blood sugar			

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F 157	Continued From page 3 levels for the month of September revealed three (3) instances when the resident's blood glucose levels were greater than four-hundred fifty (450). The dates and the levels included 09/01/10 with a blood glucose level of four-hundred ninety-two (492), 09/10/10 with a blood glucose level of five-hundred thirty-three (533) and 09/11/10 with a blood glucose level of four-hundred fifty-eight (458). Review of the Nurses' Notes for the month of September 2010 revealed no documented evidence the Medical Doctor and/or family were notified of the resident's elevated blood sugar levels on 09/01/10 and 09/11/10. When the family was notified of Unsampled Resident #1's elevated blood sugar on 09/10/10 about the resident was sent to the hospital per the family's request. Interview with the Director of Nursing (DON), on 09/24/10 at 3:00 PM, revealed nursing staff were to document when the Medical Doctor was notified. After the DON reviewed the MAR for Unsampled Resident #1 the DON stated that when the resident's blood glucose levels were greater than four-hundred fifty (450) the nurses should have notified the Medical Doctor and documented the Doctor had been notified of the incident.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced	F 221	It is the policy of Boyd Nursing and Rehabilitation Center to ensure that residents are free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The self-releasing seat belt for Resident #1 was assessed by the IDCPT	10/16/10

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F 221	Continued From page 4 by: Based on observation, interview and record review it was determined the facility failed to ensure one (1) of fifteen (15) sampled residents had a medical symptom noted related to the use of physical restraints (Resident #1). The facility failed to ensure the Physician's order included a specific diagnosis or medical symptom related to the use of a physical restraint for Resident #1. Also, the facility failed to conduct a pre-restraint evaluation, failed to notify the responsible party related to the risk versus benefits of the restraint and failed to obtain a consent. The findings include: Review of the facility's Restraint Policy and Procedure, dated 08/01/03, revealed the medical record should show evidence that methods other than restraints was initially used and that restraints were used only when other methods was not adequate. Further review of the policy revealed the Plan of Care for the restricted resident must detail plans for alternative measures and periodic re-evaluation of the resident. Continued review of the policy revealed the Physician order must include a specific diagnosis or medical symptom. Review of Resident #1's medical record revealed the resident was admitted to the facility on 02/12/10, with diagnoses which included Congestive Heart Failure and Psychosis. Review of the Resident Assessment Protocol Summary (RAPS) dated 02/25/10, revealed the facility noted the resident had a history of falls at home. Review of the resident's Plan of Care, dated 02/25/10 (last reviewed on 08/12/10),	F 221	(Interdisciplinary Care Plan Team) on 09/22/10. All required documentation including, but not limited to, assessments, physician order, consent, risks and benefits, and care planning were completed by the MDSC (minimum data set coordinator) on 09/22/10. Any Resident utilizing a device that could potentially meet the criteria of a restraint was reviewed by the DON/Designee on 10/8/10. Any device deemed to be a restraint was reviewed by the DON on 10/8/10 to ensure that all documentation including, but not limited to, assessment, physician order, consent, risks and benefits, and care planning, were documented in the medical record. The IDCPT and all licensed staff received additional education by the DON on 10/11/10 regarding the RAI criteria utilized to determine what constitutes a restraint and the documentation requirements that must be included in the medical record. The DON/Designee will conduct audit weekly for four weeks on all residents utilizing a restraint to ensure that required documentation is included in the medical record. The DON/Designee will audit any new restraint to ensure that appropriate documentation is included in the medical record. The results of these audits will be forwarded	

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F 221	Continued From page 5 revealed the resident was at risk for falls due to muscle weakness and decreased safety awareness. Interventions included the use of an alarming seatbelt when up in a wheelchair. Review of Resident #1's Quarterly Minimum Data Set (MDS) dated 08/12/10 revealed the resident was assessed by the facility as being moderately impaired in cognitive skills and required extensive assistance with activities of daily living (ADLS). The facility assessed the resident as using a trunk restraint, daily.	F 221	to Weekly Focus Meeting to determine that all appropriate documentation is recorded and follow-up in place. The results will be forwarded to the monthly CQI Committee for further monitoring and continued compliance.	
	Review of the current Physician orders, dated September 2010, revealed an order for a self releasing alarming seatbelt when up in a wheelchair, no medical symptom was identified. Observation of Resident #1 on 09/21/10 at 1:00 PM, 5:00 PM, 09/22/10 at 7:25 AM, 8:30 AM, and 3:00 PM, revealed a seatbelt was utilized when resident was in the wheelchair. Further review of the medical record revealed there was no documented evidence a pre-restraint assessment had been completed prior to the use of the seatbelt/restraint. In addition there was no evidence the risk versus benefits were explained to the responsible party or a consent obtained from the responsible party related to the use for the seatbelt/restraint. Nor was there any documented evidence of a physician's order reflecting the presence of a medical symptom related to the use of this restraint. Interview with the MDS Coordinator, on 09/22/10 at 4:15 PM, confirmed there was no signed consent form related to the use of the			

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F 221	Continued From page 6 seatbelt/restraint in the resident's medical record. The MDS Coordinator stated we must complete a restraint assessment and obtain a consent form for restraint use, but I can't find it anywhere in the resident's medical record.	F 221		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services were provided which met professional Standards of Quality Care and were provided according to Standards of Clinical Practice for one (1) of fifteen (15) sampled residents (Resident #3), and one (1) Unsampled resident (Resident #A). Resident #3 was allowed to self administer medication however, was assessed by the facility as not having the ability to self administer medications. Unsampled Resident A had a physician's order to notify the physician of blood sugar reading of over 450. However, there was no documented evidence this occurred, consistently. The findings include: 1. Review of the clinical record for Resident #3 revealed in the Assessment For Ability to Self Administer Medications which revealed the response to the assessment question "Is the resident able to correctly demonstrate proper administration of nebulized or inhaled medications?" was " no" for the assessment	F 281	It is the policy of Boyd Nursing and Rehabilitation Center to assure services provided or arranged by the facility shall meet professional standards of quality. Resident #3 has been re-assessed to determine ability to administer own medications on 09/29/10. The Physician was notified of resident's status of utilizing the inhaler on 09/29/10. No new orders received. Physician visited unsampled Resident #1 on 09/30/10 related to her blood glucose levels. New orders were received and implemented by the charge nurse. All resident records for the previous 30 days were reviewed by the Director of Nursing or designee as of 10/11/10 to determine current orders are noted appropriately and implemented as directed by the physician according to Professional Standards of Practice. All nurses received additional education regarding the following Physician Orders as directed by the Physician policy according to Professional Standards of Practice. This education was completed by the Director of Nursing on 10/06/10.	10/16/10

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F 281	Continued From page 7 dates of 05/25/10, 06/11/10, and 08/10/10. Observation of Resident #3 on 09/22/10 at 8:15 AM revealed Licensed Practical Nurse (LPN) #2 handed Resident #3 his/her Spiriva Inhaler. Resident #3 inhaled and immediately exhaled the inhalation. Interview with (LPN) #2 on 09/22/10 at 8:20 AM, who provided the inhaler to the resident, revealed the resident could not hold the inhalant because the resident panics and thinks he/she cannot breathe when holding his/her breath the required time needed to absorb the dose. Further interview revealed LPN #2 thought Resident #3 was not effectively using the inhaler medication. Interview with the facility Director of Nurses, on 09/24/10 at 1:20 PM, revealed she expected any nurse at the facility to be aware of a physician's order noting a resident cannot self administer their medications. Further interview revealed if re-education of the proper technique for medication inhalation was not effective, the correct procedure would be to notify the physician of the resident's inability to use the inhaler properly. Review of the Nursing 2010 Drug Handbook revealed the correct administration of the Spiriva Inhaler to be the following: prior to using the inhaler, the user needs to breathe out, expelling as much air as possible, then seal his/her mouth around the mouthpiece, and inhale deeply as the dose is released. The user should then hold his/her breath for several seconds, remove mouthpiece, and exhale slowly. 2. Review of Unsampled Resident #1's medical	F 281	The Director of Nursing or designee will review ten charts each business day for four weeks to ensure that all physician orders are followed as directed by the physician. The results of these audits will be forwarded to the weekly Focus Committee. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. The committee will determine, based on the results of audits received, how long monitoring should continue.	

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F 281	Continued From page 8 record revealed the resident was admitted with diagnoses which included Vascular Dementia and Uncontrolled Type II Diabetes Mellitus. Review of Unsampled Resident #1's Medication Administration Record (MAR) revealed a sliding scale insulin dosage based on the resident's blood sugar levels. The MAR noted that if the resident's blood glucose levels were above four-hundred fifty (450) the Medical Doctor (MD) was to be notified. Unsampled Resident #1's MAR was reviewed and revealed blood sugar levels for the month of August included the following: on 08/04/10 the resident's blood glucose level was four-hundred ninety-six (496); on 08/08/10 the blood glucose level was documented as four-hundred sixty-nine (469); on 08/10/10 the resident's blood glucose level was noted to be four-hundred ninety-two (492); on 08/18/10 the blood glucose level was five-hundred twenty-six (526); on 08/23/10 blood his/her glucose level was four hundred eighty-nine (489) and on 08/29/10 the resident's blood glucose level was documented to have been four hundred eighty-two (482). Review of the August 2010 Nurses' Notes revealed no documented evidence the facility notified the MD related to the resident's elevated blood sugar levels on 08/04/10, 08/08/10, 08/10/10, 08/23/10 and 08/29/10. Unsampled Resident #1's MAR was reviewed and revealed blood sugar levels for the month of September included the following: on 09/01/10 the blood glucose level was noted as being four-hundred ninety-two (492); on 09/10/10 a blood glucose level of five-hundred thirty-three	F 281		

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F 281	Continued From page 9 (533) was noted and on 09/11/10 his/her blood glucose level of four-hundred fifty-eight (458). Review of the September 2010 Nurses' Notes revealed no documented evidence the MD was notified of Unsampled Resident #1's elevated blood glucose levels on 09/01/10 and 09/11/10. Interview with the Director of Nursing, on 09/24/10 at 3:00 PM, revealed nursing staff were to document when the MD was notified. The DON reviewed this resident's MAR and stated the MD should have been notified, by the nurse, related to the blood sugar levels above four-hundred and fifty (450). Review of the facilities policy entitled "Notification of Changes" (dated 08/01/03) revealed the policy statement included the Resident's physician will be notified when a life-threatening condition or clinical complications, or need to significantly alter treatment. The policy also included that a licensed Nurse would notify the MD when a change in health status occurred and document the changes, who was notified and enter this into the Nurses notes.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to	F 282	It is the policy of Boyd Nursing and Rehabilitation Center to ensure services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. The care plan for Residents #1 was reviewed and revised by the IDCPT on 9/24/10 to ensure current interventions have been implemented as written. The plan of care for each resident was	10/16/10

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 ensure the Comprehensive Plan of Care was implemented for one (1) of fifteen (15) sampled residents (Resident #1). Resident #1's Plan of Care included interventions related to the use of Geri Sleeves at all times except for hygiene, however this was not observed to have occurred. The findings include: Review of Resident #1's medical record revealed the resident was admitted to the facility on 02/12/10, with diagnoses which include Congestive Heart Failure, Chronic Kidney Disease and Diabetes. Review of the Skin Plan of Care dated 09/16/10, revealed Resident #1 had a skin tear to the left forearm. The Plan of Care included an intervention that the resident was to have Geri Sleeves on at all times, except for hygiene. Review of Resident #1's Physician orders, dated September 2010, revealed a hand written order for Geri Sleeves to be utilized to bilateral arms at all times except for hygiene, due to decreased skin integrity. Observation of Resident #1 on 09/21/10 at 3:00 PM, 5:00 PM, 09/22/10 at 9:30 AM, 3:00 PM, 09/23/10 at 8:30 AM, 2:00 PM and on 09/24/10 at 10:00 AM and 1:15 PM, revealed the resident failed to have Geri Sleeves on his/her arms. Interview on 09/24/10 at 1:25 PM with State Registered Nurse Aide (SRNA) #8, who was assigned to provide care for Resident #1, revealed she was not aware the resident was to wear Geri Sleeves. The SRNA indicated this information would be on the Care Flow Sheet.	F 282	reviewed by the IDCPT to ensure that the current plan of care is reflective of individual needs. The plan of care was utilized by the IDCPT to ensure that all recorded interventions were implemented by 10/15/10. All nursing staff received additional education by the Staff Development Nurse on 09/29/10 regarding the importance of implementation of individual interventions. The IDCPT received additional education by the DON on 10/13/10 regarding the importance of ensuring implementation of individual interventions via walking care plan rounds each week. The Director of Nursing or designee will audit all scheduled care plans for four weeks and accompany the IDCPT on walking care plan rounds. Thereafter, the Director of Nursing or designee will audit at least two care plans per week for 8 weeks to ensure implementation of interventions. The results of these audits will be forwarded to the weekly Focus Committee. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. The committee will determine, based on the results of audits received, how long monitoring should continue.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	185418	A. BUILDING _____ B. WING _____	C 09/24/2010

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F 282	Continued From page 11 Review of the Resident Care Flow Sheet with SRNA #8 revealed the use of the Geri Sleeves to bilateral arms were to be utilized. The SRNA she stated "Oh that's new I did not know". She further stated she had not reviewed the Resident Care Flow Sheet for Resident #1, that day. Interview with the Director of Nursing (DON) on 09/24/10 at 2:05 PM, revealed SRNAs were to review the Resident Care Flow Sheets each shift and note anything new related to the resident's care needs.	F 282		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure adaptive dining equipment was utilized correctly by one (1) of fifteen (15) sampled residents (Resident #8). Resident #8 had a Physician's order for the use of a scoop plate and the facility assessed the need for one as well. The scoop plate was provided however, staff failed to positioned the plate in the manner which would be more effective for the resident's use. The findings include: Review of Resident #8's medical record revealed diagnoses which included Hemiparesis related to an "old CVA", Chronic Airway Obstruction and Esophageal Reflux	F 369	It is the policy of Boyd Nursing and Rehabilitation Center to provide special eating equipment and utensils for residents who need them. Resident #8 plan of care was reviewed on 10/07/10 by the IDCPT for accuracy. No changes were made to the plan of care. All residents utilizing assistive devices had the potential to be affected by this practice. All residents currently utilizing assistive devices were re-assessed for appropriateness by the Director of Nursing or designee on 10/13/10. The Rehab Manager provided additional education on 10/13/10 to all nursing staff regarding the appropriate use of various Assistive Device-Eating Equipment/Utensils. The Director of Nursing or designee will conduct daily audits for a period of 4 weeks	10/16/10

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F 369	Continued From page 12 Review of the Annual MDS,with an assessment date of 07/09/10, revealed the facility assessed Resident #8's cognitive skills as being moderately impaired related to daily decision making. The facility indicated the resident had moderate impairment with his/her vision and required supervision while eating. Review of the RAPS, related to the Annual MDS dated 07/09/10, revealed the resident used adaptive equipment to aid with feeding his/her self. The RAPS indicated the resident did well with the use of a scooped plate. Review of the Comprehensive Plan of Care, dated 07/14/10, revealed the facility developed a Plan of Care related to Resident #8's difficulty with swallowing and the use of a medical altered diet. An intervention on th Plan of Care included the use of a scoop plate, in order to make it easier for the resident to eat. The Physician Orders, dated September 2010, were reviewed and revealed an order for the use of a scoop plate. Observation of the evening meal on 09/22/10 at 5:25 PM revealed Resident #8's scoop plate was provided. However, the scoop plate was placed at an angle in front of the resident instead of the "high" side of the plate facing the resident. Further observation of the noon meal on 09/23/10 revealed the scoop plate was observed to have been placed at an angle in front of Resident #8. Interview with the Director of Nursing (DON) and Staff Development Nurse, on 09/22/10 at 5:35 PM, revealed the scoop plate should have been	F 369	to determine that adaptive equipment is properly used by nursing staff. Results will be forwarded to the weekly Focus Meeting. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. The committee will determine, based on the results of audits received, how long monitoring should continue.	

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F 369	Continued From page 13 set in front of the resident with the "high" side toward the resident. Further interview revealed staff should have been monitoring the resident for correct usage of the plate.	F 369		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	It is the policy of Boyd Nursing and Rehabilitation Center to store, prepare, distribute, and serve food under sanitary conditions. Wet pans, mixer and thermometer were sanitized 09/21/10 by dietary staff. Food was properly covered when transported by dietary staff on 09/22/10. Labels on prepared food were checked and properly labeled by dietary staff on 09/22/10. Facility and Regional Maintenance personnel checked buffet steam table to ensure in proper working order. No issues were found. Dietary department started 10/26/10 to use steam versus dry heat to maintain proper holding temperatures. Food temperatures at taken at the beginning and middle of each meal service by dietary staff. Temperatures are recorded on the temperature log. This log is reviewed daily by Dietary Manager. No further issues have been noted. Sanitation audit including but not limited to labeling, temperature logs, storage of pans, and dishwashing techniques was conducted by the Dietary Manager on 09/26/10. No further sanitation issues were found. Policies and procedures for storing, preparing, distributing and serving food	10/16/10
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. As evidenced by pans stored wet and the mixer stored dirty. The body of the thermometer was observed to be inserted into the oatmeal while checking the temperatures on tray line and was not cleaned before continuing to check food temperatures. Foods were transported from kitchen on open cart to resident tray line in the dining area and inappropriate hot food holding temperatures were noted on the resident tray line in the dining area. The findings included: 1. Observation on 09/21/10 at 10:35 AM revealed three (3) hotel pans stored wet. Interview with the Dietary Manager on 09/21/10 at 10:35 AM			

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F 371	Continued From page 14 revealed all dishes should be air dried before storing. 2. Observation on 09/21/10 at 11:40 AM revealed the mixer was stored with a sticky brown substance pooled in the bottom. Interview with the Dietary Manager on 09/21/10 at 11:40 AM revealed the substance may have been from when the oven hoods were cleaned. Review of documentation, provided by the facility, revealed the contract cleaning company had last cleaned the hood on 06/10. 3. Observation on 09/22/10 at 7:37 AM revealed temperatures being taken with a digital thermometer by Cook #12. While taking the temperature of the oatmeal the body of the thermometer, where the temperature read out was located, was dipped into the low concentrated sweet oatmeal and was not cleaned along with the metal prong used to measure the temperatures for eight (8) additional food items. The foods that had temperatures taken after the thermometer body was soiled included the regular oatmeal, ground sausage, pureed sausage, pureed eggs, bacon, toast, milk and biscuits. Interview with Cook #12 on 09/22/10 at 8:40 AM revealed the thermometer should have been completely cleaned before continuing with taking the temperatures of the food. 4. Observation on 09/22/10 at 8:20 AM revealed food was transferred from the resident tray line in the kitchen to the buffet style resident tray line, in the main dining area. The food items were transferred on a three level cart and were observed not to be covered during the transport.	F 371	under sanitary conditions were reviewed by the Dietary Manager on 09/27/10. No changes were made to these policies. Education was provided to all dietary staff by the Dietary Manager on 9/28/10 regarding the facility policy and procedures for storing, preparing, distributing and serving food under sanitary conditions. The Dietary manager will conduct daily audits Monday through Friday for four weeks and then weekly thereafter to ensure that dietary staff is compliant with the facility protocols regarding storage, preparation, distribution and service of food. The results of these audits will be forwarded to the weekly Focus Committee. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. The committee will determine, based on the results of audits received, how long monitoring should continue.	

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F 371	Continued From page 15 5. Observation on 09/22/10 at 8:20 AM revealed inappropriate hot food holding temperature on the buffet style resident tray line. The ground sausage was noted to be held at one-hundred and twenty-four (124) degrees Fahrenheit, and bacon was noted to be held at ninety-one (91) degrees Fahrenheit. Interview with the Dietary Manager on 09/24/10 at 4:30 PM revealed the hot holding temperatures on resident tray line should be at least one-hundred and fifty (150) degrees Fahrenheit.	F 371		
	6. Observation on 09/21/10 at 10:35 AM bowls were observed to be in oven one (1) which was not labeled. Pureed carrots were dated and labeled 09/19/10 to use by 09/22/10 and cheeseburger was dated and labeled 09/20/10 use by 09/22/10. Interview with the Dietary Manger on 09/21/10 at 10:32 AM revealed the cook had stated she made the items in the bowls this morning and had dated them wrong. She further indicated she had thrown the food away because she was not sure the bowls were oven proof.			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	It is the policy of Boyd Nursing and Rehabilitation Center to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Resident #10 Foley catheter and tubing was secured and placed in a canvas bag on 09/24/10 by nursing staff.	10/16/10

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F 441	Continued From page 16 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection by direct care staff. The facility failed to ensure staff performed hand washing when needed, prevent the use of bare hands while administrating medication, and failed to ensure the use of catheter bag covers.	F 441	On 9/27/10, the Director of Nursing or designee assessed all residents with a foley catheter to ensure the catheter was secured in a canvas bag. On 10/04/10, the Administrator, Director of Nursing and Laundry Supervisor reviewed infection control policies contained in the facility Infection Control Manual. No changes were made to these policies. All staff were re-educated by Staff Development on 10/13/10 regarding importance of proper procedures to help prevent the development and transmission of disease and infection. This included, but was not limited to, handwashing techniques and the handling of foley catheter bags, use of gloves and standard precautions. The DON/Designee will monitor staff compliance with facility infection control protocols daily for four weeks. This included, but not limited to, handwashing techniques and the handling of foley catheter bags, use of gloves and standard precautions. Any staff member deviating from proper protocol will be educated at that time. The results will be forwarded to the Focus Meeting. The results will also be forwarded to the monthly CQI Committee Meeting for further monitoring and continued compliance. The Staff Development Coordinator reviews and tracks infection rates on a daily basis to monitor for trends and patterns. The results	

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F 441	Continued From page 17 The findings include: Review of the facility's "Handwashing and Hand Hygiene - All Staff" policy revealed the following examples of when hand hygiene was indicated: Before and after contact with a resident; Before preparing medications and as appropriate throughout medication distribution; and, Before and after feeding a resident. 1. During the medication pass on 09/22/10 at 7:50 AM LPN #2 was observed to prepare a Spiriva capsule (inhalation/respiratory track) with her bare hands and administer this medication to Resident #3. This LPN was observed to apply a transdermal medication to Unsampled Resident B and failed to wash her hands after making contact with Resident #B's skin. LPN #2 administered an inhaler mediation to Unsampled Resident C and was observed to not wash her hands after the medication was provided. Interview with LPN #2 on 09/22/10 at 8:50 AM revealed it was inappropriate to directly touch the Spiriva capsule with bare hands. Further interview revealed she did not wash her hands after contact with Unsampled Resident B's skin and should have done so. LPN #2 indicated the failure to wash her hands after administering the inhaler medication was inappropriate. Record review revealed LPN #2 had completed a Continuing Education inservice, provided by the facility on 08/21/10. The inservice provided was entitled "An Introduction To Infection Control", which included specific content on handwashing. 2. Record review for Resident #10 revealed diagnoses which included Dementia, Chronic	F 441	are forwarded to the weekly Focus Meeting. The committee reviews the reports and identifies trends, patterns, or problems that might reflect the development of healthcare associated infections. The results are forwarded to the monthly CQI Committee for further monitoring and continued compliance.	

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F 441	Continued From page 18 Urinary Tract Infections, and Urinary Retention. Observation, on 09/23/10 at 4:30 PM, revealed Resident #10 was noted to be lying on a low bed on his/her right side. The resident's catheter tubing was noted to exit the resident's pant leg, was attached to a catheter bag, with the tubing in contact with the floor. Observation on 09/24/10 at 12:10 PM revealed Resident #10 sitting at the bedside with the catheter tubing and bag lying directly on the floor. Interview with Certified Medication Technician (CMT) #7, on 09/24/10 at 1:10 PM, revealed the catheter bag should have been in a catheter cover bag. CMT #7 indicated the catheter bag should always be in a catheter cover bag when the resident was in the bed. She stated the tubing should also be in the bag due to the risk of infection. 3. Observation during the evening meal, on 09/21/10 at 5:35 PM, revealed SRNA #3 wiped a resident's mouth with a napkin using her bare hand and then proceeded to feed another Resident. SRNA #3 was observed to touch her hair, scratch her face and continue to feed the resident. SRNA #3 adjusted a resident's glasses, then proceeded to feed another Resident. Interview with SRNA #3, on 09/21/10 at 6:10 PM, revealed she was aware she had touched her face and hair. She further indicated she was supposed to wash or sanitize her hands after touching anything else.	F 441		

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	185418	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/22/2010

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K 000	INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on 09/22/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a " F ".	K 000	To the best of my knowledge and belief, as an agent of Boyd Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. It is the policy of Boyd Nursing and Rehabilitation Center to have a fire alarm system for life safety installed, tested and maintained in accordance with NFPA 7- National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72.	10/16/10
	This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain smoke detectors according to NFPA standards. The findings include: Review of the facility's log related to smoke detectors, on 09/22/2010 at 11:30 AM, with the Maintenance Director, revealed the facility could not produce evidence of a current sensitivity test for the smoke detectors. The last sensitivity test		A sensitivity test on the smoke detectors was conducted on 09/23/10 by Sentry Fire. Any found issues were immediately corrected. The Administrator educated the Maintenance Director on 09/23/10 concerning the responsibility of the facility to ensure companies follow our expectations in maintaining inspections and checks as they relate to regulatory compliance.	

RECEIVED
OCT 15 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/15/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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BOYD NURSING & REHABILITATION CENTER	12800 PRINCELAND DRIVE ASHLAND, KY 41102

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K 052	Continued From page 1 was conducted was on 06/06/2008. Interview on 09/22/2010 at 11:30 AM, with the Maintenance Director, revealed the facility relied on a company to check the smoke detectors. The Maintenance Director contacted the company which inspects the fire alarm system and was informed the company would visit the facility on 09/23/2010 to test the sensitivity of the smoke detectors. Reference: NFPA 72 (1999 edition) 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following	K 052	The Maintenance Director is to keep a tickler system to ensure all inspections and checks are done timely. The Maintenance Director reports any discrepancies to the monthly safety committee for review. The Safety Committee consists of the Payroll Clerk, Administrator, Director of Nursing, Housekeeping/Laundry Supervisor, Maintenance Director, Activities Director and Dietary Manager. The Safety Committee then forwards any concerns to the monthly CQI committee, consisting of Housekeeping/Laundry Supervisor, Maintenance Supervisor, Business Office Manager, Dietary Manager, MDS Coordinator, Staff Development Coordinator, Activities Director and Social Service Director for any needed follow-up.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185418	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 052	Continued From page 2 methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 052		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the	K 056	It is the policy of Boyd Nursing and Rehabilitation Center to have a sprinkler system installed in accordance with NFPA 13, Standard for the Installation of Sprinkler	10/16/10

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K 056	Continued From page 3 building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the sprinkler system was maintained according to NFPA standards. The findings include: Observation on 09/22/2010 at 10:38 AM, revealed the sprinkler systems accelerator valve was in the off position. The observation was confirmed with the Maintenance Director. Interview on 09/22/2010 at 10:38 AM, with the Maintenance Director, revealed he was unsure of why the accelerator valve was in the off position. The Maintenance Director contacted the company which provides service and inspection for the sprinkler system and this revealed that the accelerator valve should not be in the off position. Reference: NFPA 25 (1998 edition) 9-3.3 Inspection. 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA	K 056	Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. On 09/22/10 the Maintenance Director placed the sprinkler systems accelerator valve in the on position. On 09/23/10 the Administrator educated the Maintenance Director concerning the responsibility of the facility to ensure companies follow our expectations in maintaining inspections and checks as they relate to regulatory compliance. The Maintenance Director is to keep a tickler system to ensure all inspections and checks are done timely. The Maintenance Director will inspect the facility following the quarterly inspection of the sprinkler system to ensure the accelerator valve is in the on position following the inspection. The Maintenance Director reports to the monthly safety committee any discrepancies found. The Safety Committee consists of the Payroll Clerk, Administrator, Director of Nursing, Housekeeping/Laundry Supervisor,	

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K 056	Continued From page 4 standards shall be permitted to be inspected monthly. Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 9-3.3.2* The valve inspection shall verify that the valves are in the following condition: (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification	K 056	Maintenance Director, Activities Director and Dietary Manager. The Safety Committee then forwards any concerns to the monthly CQI committee, consisting of Housekeeping/Laundry Supervisor, Maintenance Supervisor, Business Office Manager, Dietary Manager, MDS Coordinator, Staff Development Coordinator, Activities Director and Social Service Director for any needed follow-up.	